Complete Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with eating disorders.

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association Work Group on Eating Disorders. Practice guideline for the treatment of patients with eating disorders (revision). Am J Psychiatry 2000 Jan;157(1 Suppl):1-39. [356 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Anorexia nervosa
- Bulimia nervosa

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide guidance to psychiatrists in the care of patients with the eating disorders anorexia nervosa and bulimia nervosa.

TARGET POPULATION

Patients with anorexia nervosa or bulimia nervosa.

INTERVENTIONS AND PRACTICES CONSIDERED

Selection of services available for treatment of eating disorders, based on patient characteristics (e.g., weight and cardiac and metabolic status):

- Level 1: Outpatient
- Level 2: Intensive outpatient
- Level 3: Partial hospitalization (full-day outpatient care)
- Level 4: Residential treatment center
- Level 5: Inpatient hospitalization

Psychiatric management, including the following important components:

- Establish and maintain a therapeutic alliance
- Coordinate care and collaborate with other clinicians
- Assess and monitor eating disorder symptoms and behaviors
- Assess and monitor the patient's general medical condition
- Assess and monitor the patient's psychiatric status and safety
- Provide family assessment and treatment

Specific treatment options for anorexia nervosa:

- Nutritional rehabilitation/counseling:
    1. Establish healthy target weights and expected rates of controlled weight gain
    2. Set intake levels, and advance progressively
    3. Vitamin and mineral supplements (e.g., phosphorous)
    4. Monitor patients during refeeding
    5. Other treatments, when indicated, including liquid food supplements; nasogastric feedings; parenteral feedings
    6. Patient education and ongoing support
- Psychosocial interventions
    1. Individual psychotherapy (e.g., cognitive behavior psychotherapy, psychodynamically oriented psychotherapy)
    2. Family or couples psychotherapy
    3. Group psychotherapy
    4. Psychosocial interventions based on addiction models
    5. Support groups led by professionals or advocacy organizations
- Medications, including antidepressants (e.g., selective serotonin reuptake inhibitors [SSRIs])

Specific treatment options for bulimia nervosa:

- Nutritional rehabilitation/counseling
- Psychosocial interventions:
    1. Individual psychotherapy (e.g., cognitive behavioral psychotherapy, interpersonal, psychodynamically oriented or psychoanalytic approaches, behavior therapy)
    2. Group psychotherapy
    3. Family and marital therapy
    4. Support groups, 12-step programs
- Medications, including antidepressants (e.g., selective serotonin reuptake inhibitors [SSRIs])

MAJOR OUTCOMES CONSIDERED

Anorexia nervosa treatment outcomes:

- Amount of weight gained within specified time intervals.
- Proportion of patients achieving a specified percentage of ideal body weight.
- Return of menses in those with secondary amenorrhea.
- Measures of the severity or frequency of eating disorder.

Bulimia nervosa treatment outcomes:

- Frequency or severity of eating disorder behaviors.
- Proportion of patients achieving elimination of or a specific reduction in eating disorder behaviors.

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

A computerized search of the relevant literature from MEDLINE was conducted.

The first literature search was conducted by searching MEDLINE for the period 1990 to July 1996 and used the key words "eating disorders", "anorexia nervosa", "bulimia nervosa", "epidemiology", "treatment", "controlled trials", "psychopharmacology", "medication", "psychotherapy", "antidepressive agents", "other psychotropic agents", "hospital treatment", and "outpatient care".

Additional literature searches were conducted by searching MEDLINE for the period 1996 to 1999 using key words from the first literature search.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and practice experience relevant to the topic. Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified at falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence.

[II] Recommended with moderate clinical confidence.

[III] May be recommended on the basis of individual circumstances.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guideline has been extensively reviewed by members of the American Psychiatric Association as well as by representatives from related fields. Thirty-eight individuals are acknowledged by name in the guideline document for submitting comments. In addition, the following nine organizations are acknowledged for submitting comments:

- American Academy of Pediatrics
- American Association of Directors of Psychiatric Residency Training
- American Association of Suicidology
- American Dietetic Association (Sports, Cardiovascular and Wellness Nutritionists)
- Anorexia Nervosa and Related Eating Disorders
- American Group Psychotherapy Association
- Black Psychiatrists of America
- Center for Eating and Weight Disorders
- Joint Commission on Accreditation of Health Care Organizations

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

General Considerations

Patients with eating disorders display a broad range of symptoms that frequently occur along a continuum between those of anorexia nervosa and bulimia nervosa. The care of patients with eating disorders involves a comprehensive array of approaches. These guidelines contain the clinical factors that need to be considered when treating a patient with anorexia nervosa or bulimia nervosa.

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendations:

- [I] recommended with substantial clinical confidence.
- [II] recommended with moderate clinical confidence.
- [III] may be recommended on the basis of individual circumstances.

1. Choosing a site of treatment

   Evaluation of the patient with an eating disorder prior to initiating treatment is essential for determining the appropriate setting of treatment. The most important physical parameters that affect this decision are weight and cardiac and metabolic status [I]. Patients should be psychiatrically hospitalized before they become medically unstable (i.e., display abnormal vital signs) [I]. The decision to hospitalize should be based on psychiatric, behavioral, and general medical factors [I]. These include rapid or persistent decline in oral intake and decline in weight despite outpatient or partial hospitalization interventions, the presence of additional stressors that interfere with the patient's ability to eat (e.g., intercurrent viral illnesses), prior knowledge of weight at which instability is likely to occur, or comorbid psychiatric problems that merit hospitalization.

   Most patients with uncomplicated bulimia nervosa do not require hospitalization. However, the indications for hospitalization for these patients can include severe disabling symptoms that have not responded to outpatient treatment, serious concurrent general medical problems (e.g., metabolic abnormalities, hematemesis, vital sign changes, and the appearance of uncontrolled vomiting), suicidality, psychiatric disturbances that warrant hospitalization independent of the eating disorders diagnosis, or severe concurrent alcohol or drug abuse.

   Factors influencing the decision to hospitalize on a psychiatric versus a general medical or adolescent/pediatric unit include the patient's general medical status, the skills and abilities of local psychiatric and general medical staffs, and the availability of suitable intensive outpatient, partial and day hospitalization, and aftercare programs to care for the patient's general medical and psychiatric problems.

2. Psychiatric management

   Psychiatric management forms the foundation of treatment for patients with eating disorders and should be instituted for all patients in combination with other specific treatment modalities. Important components of psychiatric management for patients with eating disorders are as follows: establish and maintain a therapeutic alliance; coordinate care and collaborate with other clinicians; assess and monitor eating disorder symptoms and behaviors; assess and monitor the patient's general medical condition; assess and monitor the patient's psychiatric status and safety; and provide family assessment and treatment [I].

3. Choice of specific treatments for anorexia nervosa

   Goals in the treatment of anorexia nervosa include restoring healthy weight (i.e., weight at which menses and ovulation in females, normal sexual drive and hormone levels in males, and normal physical and sexual growth and development in children and adolescents are restored); treating physical complications; enhancing patients' motivations to cooperate in the restoration of healthy eating patterns and to participate in treatment; providing education regarding healthy nutrition and eating patterns; correcting core

maladaptive thoughts, attitudes, and feelings related to the eating disorder; treating associated psychiatric conditions, including defects in mood regulation, self-esteem, and behavior; enlisting family support and providing family counseling and therapy where appropriate; and preventing relapse.

a. Nutritional rehabilitation/counseling

A program of nutritional rehabilitation should be established for all patients who are significantly underweight [I]. Healthy target weights and expected rates of controlled weight gain (e.g., 2-3 lb/week for most inpatient and 0.5-1 lb/week for most outpatient programs) should be established. Intake levels should usually start at 30-40 kcal/kg per day (approximately 1000-1600 kcal/day) and should be advanced progressively. This may be increased to as high as 70-100 kcal/kg per day during the weight gain phase. Intake levels should be 40-60 kcal/kg per day during weight maintenance and for ongoing growth and development in children and adolescents. Patients who have higher caloric intake requirements may be discarding food, be vomiting, be exercising frequently, have increased nonexercise motor activity (e.g., fidgeting), or have truly higher metabolic rates. Vitamin and mineral supplements may also be beneficial for patients (e.g., phosphorus supplementation may be particularly useful to prevent serum hypophosphatemia).

It is essential to monitor patients medically during refeeding [I]. Monitoring should include assessment of vital signs as well as food and fluid intake and output; electrolytes (including phosphorus); and the presence of edema, rapid weight gain (associated primarily with fluid overload), congestive heart failure, and gastrointestinal symptoms, particularly constipation and bloating. Cardiac monitoring may be useful, especially at night, for children and adolescents who are severely malnourished (weight <70% of the standard body weight). Physical activity should be adapted to the food intake and energy expenditure of the patient.

Nutritional rehabilitation programs should also attempt to help patients deal with their concerns about weight gain and body image changes, educating them about the risks of their eating disorder and providing ongoing support to patients and their families [I].

b. Psychosocial interventions

The establishment and maintenance of a psychotherapeutically informed relationship is beneficial [II]. Once weight gain has started, formal psychotherapy may be very helpful. There is no clear evidence that any specific form of psychotherapy is superior for all patients. Psychosocial interventions need to be informed by understanding psychodynamic conflicts, cognitive development, psychological defenses, and complexity of family relationships as well as the presence of other psychiatric disorders. Psychotherapy alone is generally not sufficient to treat severely malnourished patients with anorexia nervosa. Ongoing treatment with individual

psychotherapeutic interventions is usually required for at least a year and may take 5-6 years because of the enduring nature of many of the psychopathologic features of anorexia nervosa and the need for support during recovery.

Both the symptoms of eating disorders and problems in familial relationships that may be contributing to the maintenance of disorders may be alleviated by family and couples psychotherapy [II]. Group psychotherapy is sometimes added as an adjunctive treatment for anorexia nervosa; however, care must be taken to avoid patients competing to be the thinnest or sickest member or becoming excessively demoralized through observing the difficult, chronic course of other patients in the group.

c. Medications

Treatment of anorexia nervosa should not rely on psychotropic medications as the sole or primary treatment [I]. An assessment of the need for antidepressant medications is usually best made following weight gain, when the psychological effects of malnutrition are resolving. These medications should be considered for the prevention of relapse among weight-restored patients or to treat associated features of anorexia nervosa, such as depression or obsessive-compulsive problems [II].

4. Choice of specific treatments for bulimia nervosa

a. Nutritional rehabilitation/counseling

Nutritional counseling as an adjunct to other treatment modalities may be useful for reducing behaviors related to the eating disorder, minimizing food restriction, increasing the variety of foods eaten, and encouraging healthy but not excessive exercise patterns [I].

b. Psychosocial interventions

A comprehensive evaluation of individual patients, their cognitive and psychological development, psychodynamic issues, cognitive style, comorbid psychopathology, patient preferences, and family situation is needed to inform the choice of psychosocial interventions [I]. Cognitive behavioral psychotherapy is the psychosocial treatment for which the most evidence for efficacy currently exists, but controlled trials have also shown interpersonal psychotherapy to be very useful. Behavioral techniques (e.g., planned meals, self-monitoring) may also be helpful. Clinical reports have indicated that psychodynamic and psychoanalytic approaches in individual or group format may be useful once bingeing and purging are improving. Patients with concurrent anorexia nervosa or severe personality disorders may benefit from extended psychotherapy.

Whenever possible, family therapy should be considered, especially for adolescents still living with parents or older patients with ongoing conflicted interactions with parents or other family members [II].

c. Medications

For most patients, antidepressant medications are effective as one component of an initial treatment [I]. Selective serotonin reuptake inhibitors (SSRIs) are currently considered to be the safest antidepressants and may be especially helpful for patients with significant symptoms of depression, anxiety, obsessions, or certain impulse disorder symptoms or for those patients who have had a suboptimal response to previous attempts at appropriate psychosocial therapy. Other antidepressant medications from a variety of classes can reduce the symptoms of binge eating and purging and may help prevent relapse among patients in remission.

While tricyclic and monoamine oxidase inhibitor (MAOI) antidepressants can be used to treat bulimia nervosa, tricyclics should be used with caution for patients who may be at high risk for suicide attempts, and MAOIs should be avoided for patients with chaotic binge eating and purging.

Emerging evidence has shown that a combination of psychotherapeutic interventions and medication results in higher remission rates and therefore should be considered when initiating treatment for patients with bulimia nervosa [II].

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

To identify the type of evidence supporting the major recommendations, each is keyed to one or more references and each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence in the guideline document. Minor recommendations not keyed to references may be assumed to be based on expert opinion.

The following coding system is used to indicate the nature of the supporting evidence in the references listed in the guideline document:

- [A] Randomized clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; both the subjects and the investigators are blind to the assignments.
- [B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally; study does not meet standards for a randomized clinical trial.
- [C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.

- [D] Case-control study. A study in which a group of patients and a group of control subjects are identified in the present and information about them is pursued retrospectively or backward in time.
- [E] Review with secondary analysis. A structured analytic review of existing data, e.g., a meta-analysis or a decision analysis.
- [F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.
- [G] Other. Textbooks, expert opinion, case reports, and other reports not included above.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

A comprehensive approach to care of patients with eating disorders may improve clinical outcomes. The aims of treatment are to 1) restore patients to healthy weight (at which menses and normal ovulation in females, normal sexual drive and hormone levels in males, and normal physical and sexual growth and development in children and adolescents are restored); 2) treat physical complications; 3) enhance patients' motivations to cooperate in the restoration of healthy eating patterns and to participate in treatment; 4) provide education regarding healthy nutrition and eating patterns; 5) correct core dysfunctional thoughts, attitudes, and feelings related to the eating disorder; 6) treat associated psychiatric conditions, including defects in mood regulation, self-esteem, and behavior; 7) enlist family support and provide family counseling and therapy where appropriate; and 8) prevent relapse.

Efficacy of specific interventions for anorexia nervosa:

- Nutritional rehabilitation: The goals of nutritional rehabilitation for seriously underweight patients are to restore weight, normalize eating patterns, achieve normal perceptions of hunger and satiety, and correct biological and psychological sequelae of malnutrition. The efficacy with which weight restoration can be achieved varies with treatment setting. Considerable evidence suggests that with nutritional rehabilitation, other eating disorder symptoms diminish as weight is restored, although not necessarily to the point of disappearing. Clinical experience suggests that with weight restoration, food choices increase, food hoarding decreases, and obsessions about food decrease in frequency and intensity. However, it is by no means certain that abnormal eating habits will improve simply as a function of weight gain
- Psychosocial treatments: The goals of psychosocial treatments are to help patients 1) understand and cooperate with their nutritional and physical rehabilitation; 2) understand and change the behaviors and dysfunctional attitudes related to their eating disorder; 3) improve their interpersonal and social functioning; and 4) address comorbid psychopathology and psychological conflicts that reinforce or maintain eating disorder behaviors. Achieving these goals often requires an initial enhancement of patients' motivation to change along with ongoing efforts to sustain this motivation. Few systematic trials of psychosocial therapies have been completed, and a few others are under way. Most evidence for the efficacy of psychosocial therapies comes from case reports or case series. Additional evidence comes

from the considerable clinical experience that suggests a well-conducted regimen of psychotherapy plays an important role in both ameliorating the symptoms of anorexia nervosa and preventing relapse.

- Antidepressants: Medications are used most frequently after weight has been restored to maintain weight and normal eating behaviors as well as treat psychiatric symptoms associated with anorexia nervosa. Antidepressants may be considered after weight gain when the psychological effects of malnutrition are resolving, since these medications have been shown to be helpful with weight maintenance. In one controlled trial, weight-restored patients with anorexia nervosa who took fluoxetine (average 40 mg/day) after hospital discharge had less weight loss, depression, and fewer rehospitalizations for anorexia nervosa during the subsequent year than those who received placebo. Selective serotonin reuptake inhibitors (SSRIs) are commonly considered for patients with anorexia nervosa whose depressive, obsessive, or compulsive symptoms persist in spite of or in the absence of weight gain.

Efficacy of specific interventions for bulimia nervosa:

- Nutritional rehabilitation: Reducing binge eating and purging are primary goals in treating bulimia nervosa. Because most patients described in the bulimia nervosa psychotherapy treatment literature have been of normal weight, weight restoration is usually not a focus of therapy as it is with patients with anorexia nervosa. Even among patients of normal weight, nutritional counseling can be used to accomplish a variety of goals, such as reducing behaviors related to the eating disorder, minimizing food restriction, correcting nutritional deficiencies, increasing the variety of foods eaten, and encouraging healthy but not excessive exercise patterns. There is some evidence that treatment programs that include dietary counseling and management as part of the program are more effective than those that do not.
- Psychosocial treatments: Cognitive behavioral psychotherapy, specifically directed at the eating disorder symptoms and underlying cognitions in patients with bulimia nervosa, is the psychosocial intervention that has been most intensively studied and for which there is the most evidence of efficacy. Significant decrements in binge eating, vomiting, and laxative abuse have been documented among some patients receiving cognitive behavior therapy; however, the percentage of patients who achieve full abstinence from binge/purge behavior is variable and often includes only a minority of patients. Among studies with control arms, cognitive behavior therapy has been shown to be superior to waiting list, minimal intervention, or nondirective control conditions. In most of the published cognitive behavior therapy trials, significant improvements in either self-reported or clinician-rated mood have been reported. Clinical experience suggests that other types of individual psychotherapy, such as interpersonal, psychodynamically oriented, or psychoanalytic approaches can help in the treatment of the comorbid mood, anxiety, personality, interpersonal, and trauma- or abuse-related disorders that frequently accompany bulimia nervosa. Evidence for the efficacy of these treatments for bulimia nervosa comes mainly from case reports and case series.
- Medications: Medications, primarily antidepressants, are used to reduce the frequency of disturbed eating behaviors such as binge eating and vomiting. In addition, pharmacotherapy is employed to alleviate symptoms that may

accompany disordered eating behaviors, such as depression, anxiety, obsessions, or certain impulse disorder symptoms. Although wide variability exists across studies, reductions in binge eating and vomiting rates in the range of 50%-75% have been achieved with active medication. The available studies also suggest that antidepressants improve associated comorbid disorders and complaints such as mood and anxiety symptoms. Some studies show improved interpersonal functioning with medication as well. Several antidepressant agents that have demonstrated efficacy among patients with bulimia nervosa in double-blind, placebo-controlled studies including tricyclic compounds, the SSRI fluoxetine and other antidepressants. To date, the only medication approved by the Food and Drug Administration for bulimia nervosa is fluoxetine.

POTENTIAL HARMS

Side effects and toxicity associated with treatment of anorexia nervosa:

- Nutritional rehabilitation: Although weight gain results in improvement in most of the physiological complications of semistarvation, including improvement in electrolytes, heart and kidney function, and attention and concentration, many adverse physiological and psychological symptoms may appear during weight restoration. Refeeding edema and bloating are frequent occurrences. In rare instances, congestive heart failure may also develop. Patients may experience abdominal pain and bloating with meals. Hypophosphatemia, which can be life threatening, can emerge during refeeding when reserves are depleted. Constipation can occur, which can progress to obstipation and acute bowel obstruction. As weight gain progresses, many patients also develop acne and breast tenderness. Many patients become unhappy and demoralized about resulting changes in body shape.
- Psychosocial treatments: None stated.
- Medications: Malnourished, depressed patients are more prone to the side effects of and less responsive to the beneficial effects of tricyclics, selective serotonin reuptake inhibitors (SSRIs), and other novel antidepressant medications than depressed patients of normal weight. For example, the use of tricyclics may be associated with greater risks of hypotension, increased cardiac conduction times, and arrhythmia, particularly in purging patients whose hydration may be inadequate and whose cardiac status may be nutritionally compromised. Because of the reported higher seizure risk associated with bupropion in purging patients, this medication should not be used in such patients.

Side effects and toxicity associated with treatment of bulimia nervosa:

- Nutritional rehabilitation: None stated.
- Psychosocial treatments: Patients occasionally have difficulty with certain elements of psychotherapy. For example, among patients receiving cognitive behavior therapy, some are quite resistant to self-monitoring while others have difficulty mastering cognitive restructuring. Many patients are initially resistant to changing their eating behaviors, particularly when it comes to increasing their caloric intake or reducing exercise. However, complete lack of

acceptance of the approach appears to be rare, although this has not been systematically studied.

- Medications: Side effects vary widely across studies depending on the type of antidepressant medication used. For the tricyclic antidepressants, common side effects include sedation, constipation, dry mouth, and, with amitriptyline, weight gain. The toxicity of tricyclic antidepressants in overdose, up to and including death, also dictates caution in patients who are at risk for suicide. For fluoxetine, the most common side effects were insomnia, nausea and asthenia. Sexual side effects are also common in patients receiving SSRIs. For patients with bulimia nervosa who require mood stabilizers, lithium carbonate is problematic, since lithium levels may shift markedly with rapid volume changes.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The American Psychiatric Association develops derivative products including patient guides, quick reference guides, and quality of care indicators with research studies to evaluate the effectiveness of the guideline.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association Work Group on Eating Disorders. Practice guideline for the treatment of patients with eating disorders (revision). Am J Psychiatry 2000 Jan;157(1 Suppl):1-39. [356 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1993 (updated 2000 Jan)

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on Eating Disorders

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Names of Work Group Members: Joel Yager, MD, Chair; Arnold Andersen, MD; Michael Devlin, MD; Helen Egger, MD; David Herzog, MD; James Mitchell, MD; Pauline Powers, MD; Alayne Yates, MD; Kathyrn Zerbe, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities many contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of the available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Office of Research. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline.

This is an update of a guideline previously issued in 1993.

The guideline will be considered current, unless the guideline developer publishes revisions or a withdrawal.

GUIDELINE AVAILABILITY

Electronic copies are available at the American Psychiatric Association's Web site.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Ordering Information:

2000/76 pages/ISBN 0-89042-314-8/paperback/$26.50/ Order No. 2314. Ordering information is also available online at the APPI Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

American Psychiatric Association practice guideline development process. In: Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium 2000. Washington, DC: APA, 2000.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1000 Wilson Boulevard, Suite 1825, Arlington, VA 22209-3901; (703) 907-7322; (800) 368-5777; Fax (703) 907-1091.

Ordering Information:

- 2000/768 pages/ISBN 0-89042-315-6/paperback/ $49.95/Order #2315
- 2000/768 pages/ISBN 0-89042-312-1/hardcover/ $64.95/Order #2312

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on December 1, 1998. The information was verified by the guideline developer on January 11, 1999. This summary was updated by ECRI on November 28, 2000. The updated information was verified by the guideline developer as of December 18, 2000.

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